Form UB-126

Request for Reconsideration/Appeal
(Unemployment Insurance Benefits)

This form is used to request reconsideration or file an appeal of a:

- Determination of Deputy (UB-100)
- Determination of Overpayment (UB-272)
- Labor Dispute Decision (no form number)

IF YOU ARE A CLAIMANT - Your mailing address, full name, Social Security number and name of your last employer must be written or typed in the spaces provided at the top of the form.

IF YOU ARE AN EMPLOYER - Type or write your business name and mailing address in the space provided. Also include the full name and Social Security number of the claimant(s) to whom the Determination applies.

FORM COMPLETION INSTRUCTIONS FOR BOTH CLAIMANT AND EMPLOYER

Then check the box indicating that you disagree with the Determination and write or type in the date it was issued (the date is shown on the Determination you are appealing). If the Determination created an overpayment, check the second box and write or type in the date the Determination of Overpayment was issued.

NOTE: If you are appealing a Determination of Overpayment that was **not** created by a Determination of Deputy, for example, if you are a claimant and were overpaid because of unreported earnings, enter the appropriate information in the "I disagree with the Determination of Deputy" area.

The next step is to identify the particular issue (the reason for the disqualification, overpayment or charge to the employer's experience rating account). The following is an abbreviated list of the most common issues that affect an individual's eligibility for or receipt of Unemployment Insurance benefits:

- A voluntarily quit or discharge from a last employer

  (the reason for separation from a last employer is the only type of issue within this list which has an affect on an employer's Experience Rating Account)
- Unavailable for or not actively looking for work
- An illness or physical condition prevented (or continues to prevent) a claimant from working or actively looking for work
- Receipt of vacation, holiday or sick pay during a week in which benefits were claimed

- Receipt of a deductible pension or Social Security benefits
- A refusal of an offer of suitable work without good cause

You now need to state why you believe the Determination is in error (you may use an additional sheet of paper if needed).

The area on the form relating to the timeliness of your appeal is to be completed when your request is not filed within the 15-day reconsideration/appeal period. You must provide a reason why your request is untimely.

The last step is to print the form, sign and date it. You may then **mail or fax** the completed Request for Reconsideration/Appeal form to the address/fax number shown on the Determination.

SPECIAL NOTE TO EMPLOYERS: Determinations which affect your **Unemployment Insurance Tax liability** provide separate appeal rights. In all cases, an appeal must be made in writing and mailed to the address shown on the determination within the time period specified.

UB-126 (10-97)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY

REQUEST FOR RECONSIDERATION/APPEAL

Este documento afecta su elegibilidad para Seguro por Desempleo. Si usted no lee inglés, comuníquese con su oficina local o busque quien le traduzca. La audiencia se conducirá en inglés.

Name and Address of Appellant

In the Matter of the Claim of:

CLAIMANT'S NAME
SOC. SEC. NO.
EMPLOYER'S NAME

☐ I disagree with the Determination of Deputy dated _____ , involving the issue of _____ , and allege it is in error for the following reasons:

_____

_____

☐ I also disagree with the Determination of Overpayment dated _____ created by the above Determination of Deputy.

If request is not timely, state reason _____

_____

APPELLANT'S SIGNATURE	DATE

NOTICE TO CLAIMANT

If your Request for Reconsideration is denied, and you are still unemployed and wish to claim benefits, you should continue to file claims pending disposition of your appeal.

COMPLETED BY DEPARTMENT REPRESENTATIVE

REQUEST FILED:

☐ In person on _____ *(Date)*

☐ By mail postmarked on _____ *(envelope attached)*

Received at _____ on _____
(Local Office No.) *(Date)*

Claimant requests interpreter ☐ Yes _____ ☐ No ☐ Information not available
(Language)

NOTICE TO APPELLANT REGARDING RECONSIDERATION

☐ Your request has been reviewed and a reconsidered Determination of Deputy will be issued.

☐ Your request for reconsideration has been denied on _____ and this action will be forwarded to the Office of Appeals. The specific date and location for your appeal hearing will be provided in a separate communication. The hearing will be conducted in English **(unless you request an interpreter).**
(Date)

BY *(Department Representative)*	APPROVED *(UI Manager)*	PAU-174	RESOLUTION CODE	ISSUE ID	PROGRAM CODE